

Bureau Talk

September 2015

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>

Bureau Welcomes New Employees



Leslie Butler



Kelly Colwell



Samantha Joiner



Sharon Raithel



Beverly Rex



Tonya Strauss



Robin Swarnes



Parrie Veo

Since the last publication of the Bureau Talk we have hired eight new health facilities nursing consultants! They are Beverly Rex, Parrie Veo, Samantha Joiner, Sharon Raithel, Kelly Colwell, Tonya Strauss, Robin Swarnes and Leslie Butler. These new surveyors bring to the bureau a vast amount of work experience including home health, hospice and state survey experience. They will assist with home health and hospice surveys statewide. Please join us in welcoming them to our team!

Other Staff Changes

It was due to the federal Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) Act 2014, which became effective April 1, 2015, mandating hospices to be surveyed every 3 years, that the Bureau of Home Care and Rehabilitative Standards received funding to hire the new health facility nursing consultants. With this significant increase in new staff, there comes a huge need for extensive training and orientation. In order to meet the training needs of each new surveyor the bureau knew it was time to put in place an intense comprehensive orientation program, needing a full year to complete. Fern Dewert has accepted and has been fulfilling the role of the trainer. Fern has been with the Bureau for 24 years as a surveyor. In addition to her new duties she will continue in assisting with home health and hospice surveys across the state, as she mentors the new surveyors.

In addition to the above duties, Fern has also accepted the role of OASIS education coordinator. For the last 11 years, Joyce Rackers has been serving as the OASIS education coordinator, and has done an exceptional job. Joyce will continue to serve as assistant bureau administrator while continuing to address the OASIS educational needs throughout 2015, assisting Fern in the transition period.

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Transportation Services Catalog

The Department of Health and Senior Services Access to Care Implementation Team and numerous public health system partners have created a catalog of transportation services that can help locate free or low cost resources available to assist Missourians with transportation to medical appointments. This Transportation Services Catalog is now available on the department's website at: <http://www.health.mo.gov/atoz/pdf/transportationservices.pdf>. The department will maintain this resource and update it as information becomes available.

Place the link on your own agency's website to the transportation resource on the DHSS website.

1. Share this resource with your staff or other health care providers
2. Provide this resource to community coalitions, churches, schools, etc. and encourage them to share with those they serve.

Please share this resource widely to help address the transportation challenges of Missourians related to accessing health care.

Implementation of ICD-10-CM

The October 1, 2015 implementation of ICD-10-CM is quickly approaching. Many home health agencies have implemented dual coding using ICD-9-CM and ICD-10-CM. Because of the 60-day payment episode, a patient admitted on August 3, 2015 through September 30, 2015 will have the Request for Anticipated Payment (RAP) submitted with ICD-9-CM diagnosis codes. If the patient's dates of service span through October 1, 2015 or later, the home health agency must submit the end of episode (EOE) claim with ICD-10-CM diagnosis codes. In order to assure an uninterrupted billing cycle, the Centers for Medicare and Medicaid Services (CMS) recommend the RAP be dual coded with both ICD-9-CM

and ICD-10-CM codes, transmitting only the ICD-9-CM codes. The EOE claim occurring on or after October 1 will transmit only the ICD-10-CM codes.

For hospice agencies, the transition to ICD-10-CM is based on the date of service or for hospice, the benefit period. For services performed on or after October 1, 2015 the claim must contain ICD-10 diagnosis codes. Because the diagnoses are defined at the beginning of the benefit period, it was recommended hospice agencies start dual coding for benefit periods beginning July 4, 2015 through September 30, 2015.

Reminders & Other News

Family Care Safety Registry/Employee Disqualification List

This is just a reminder to agencies that Family Care Safety Registry (FCSR) must be checked prior to patient contact. The Employee Disqualification List (EDL) must be checked prior to hiring the employee.

Although the FCSR is not a requirement for hospices, if using the FCSR to check their employees for EDL then the FCSR would have to be checked prior to hire. 19 CSR 30.010(2) (M) (1) (B) (XIII)

If your agency is a hospital based agency and the employee becomes employed with the home health or hospice agency, the EDL and FCSR must be rechecked. The same applies if an employee moves from one agency to another but in the same corporation. Each agency has its own provider number and therefore the EDL and FCSR must be rechecked for any new employee.

Alzheimer's Training

Nowhere in the state regulations for home health or hospice, 19 CSR 30-26.010(1) (B) and 19 CSR 30.010(2) (M) (1) (B) (XIII), does it state that an agency must test an employee on their Alzheimer's training. However, testing is a good way for the agency to determine if their employees understood the material presented.

Surveyors have found that some agencies who are using the Missouri Alliance for Home Care (MAHC) Alzheimer's Training video are not presenting the handouts that go with the training therefore, the employee is not getting the entire required training. Both the video and the handout are required in order to meet the requirements of the regulation.

Physician Orders

The bureau would like to remind agencies about the following:

- Incomplete orders should not be accepted from the physician. For example, if a medication order is not complete or the dosage is outside the norm, the clinician must contact the physician for verification and completion of the order.
- Orders for orthotics, braces and wraps with frequency and duration should be on the plan of care. Per CFR 484.18 regulation, the plan of care development should include all pertinent diagnoses, treatments and safety measures and any other appropriate items. Surveyors expect to see specifics on the plan of care, including frequency and duration.

Encrypted E-mails

Periodically the bureau is contacted by providers stating they have received notification that an e-mail from our office has been encrypted and requires the setup of a password in order to retrieve the message. This is a safety measure established by our IT department and cannot be removed by our staff. Individuals receiving the e-mail notification will be required to follow the instructions provided in the e-mail in order to establish a password. This setup will only be a onetime setup for that particular individual and the password should be kept for future reference in the event that an encrypted e-mail from our office is received in the future.

Hospice Item Set (HIS)

Although HIS is not part of the surveying responsibilities of the bureau, we are aware that for our hospice agencies this is a high priority discussion item. Hospices have been collecting and submitting HIS data for quite some time now. We know your goal is to ensure your practices and efforts are compliant and efficient.

To help you keep current and to perhaps assist with some of your questions, the Hospice Item Set (HIS) CMS web page provides updates, announcements, and resources specific to the HIS. On this page you will find direct links to the HIS, the HIS manual, fact sheets and training materials. Announcements related to HIS activities (such as trainings and OMB approval) are also posted here.

CMS is also posting quarterly HIS Q&As on this web page. This document contains a listing of some significant questions and answers received and processed by the CMS HIS Help Desk during the previous quarter.

All of these documents can be accessed at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html. You can also contact the CMS Quality Help Desk at: HospiceQualityQuestions@cms.hhs.gov for any questions you may have.

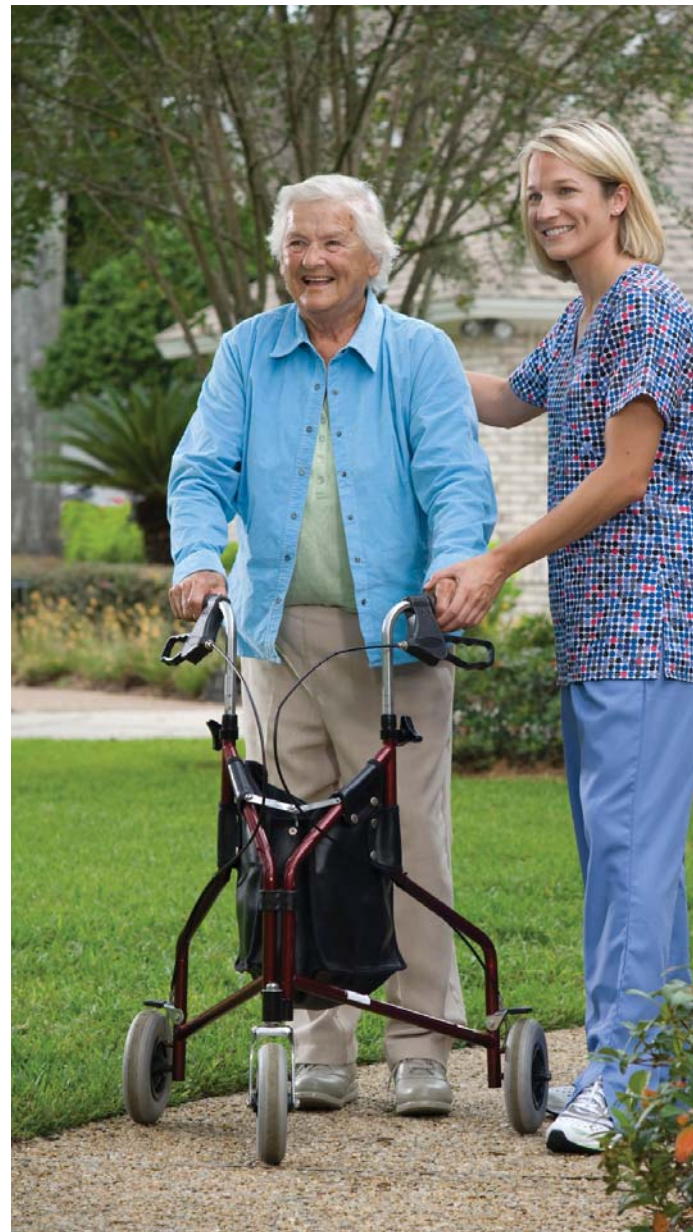
Standing Orders

The bureau has received several calls again regarding standing orders for hospices. Can hospices use standing orders? The answer is yes. Per state regulations, 19CSR 30-35.010(1) (A) (37) and 19 CSR 30-35.010(2) (E) (3) and (4), standing orders can be part of the plan of care; however, certain guidelines must be met.

Agencies need to remember when developing your agency's standing orders:

- Each procedure, medication or treatment should be addressed in a separate order on the overall standing orders.
- Each procedure, medication or treatment should have specific criteria or qualifications for use such as the medical indication, purpose or conditions of use. These criteria should be as specific as possible and not allow nurses' choice.
- Standing orders should not include normal teaching processes, instructions to caregivers, etc.
- Standing orders must be signed and dated by the physician.
- Medical director must review all standing orders annually.
- There should be policies in place as to when and how to use the standing orders and a method to show physician notification of use of standing orders.
- Standing orders must be patient individualized.
- No narcotics on standing orders.

The bureau would like to remind agencies though, that best practice is to get new orders as a patient's condition requires.



Bereavement Assessments

A question has recently come to the bureau regarding bereavement risk assessments. Most agencies do a risk assessment on the caregiver which is usually a spouse, son or daughter, but what if there are many more potential caregivers? Do the surveyors expect to see a bereavement assessment on the whole family or all potential caregivers? The surveyors would expect to see a bereavement assessment on anyone whom through the course of the care, the hospice has been told directly or perhaps they have discovered incidentally, may have difficulty with the grieving process.

Another issue to discuss is bereavement for family members that do not live in close proximity to the patient. A question that has again come up is what if family members were assessed to need bereavement services but they live in another state and once the patient dies they move back home? Is the hospice agency still expected to offer this family bereavement services? The bureau wouldn't expect a hospice to provide an in-person bereavement visit to a family who lives hundreds of miles away; however, on the other hand if they were having issues we would expect the hospice to try and locate some help in their area, by giving them some resources to contact that could help them with their grieving. We wouldn't expect them to pay for therapy; however, we have heard of hospices in other states, agreeing to have a family person join their support group if needed. When there are many miles separating the hospice employees from the family member we feel they can always communicate via email, phone calls or postal mail if there was a need.

Survey Activity

Due to the federal Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) Act 2014, mandating hospices to be surveyed every 3 years, the number of hospice Medicare certification surveys will be increasing.

Many hospice agencies have not been surveyed since the new federal regulations were published in December of 2008. At that time, the federal regulations doubled and there are now many different areas the surveyors are now surveying for that were not part of the survey process seven (7) years ago. Hospice agencies are finding that they are being cited for non-compliance in areas they have never been cited for in the past. The reaction of many of these agencies is that they do not understand why this is occurring when they have been doing these practices for years and have never been cited.

This is just a reminder to all hospice agencies, that there are new regulations. This changes the survey process. The bureau survey staff has also doubled and with new people come new thoughts, perspectives and interpretations. With that being said, the bureau still strives to be as consistent as humanly possible across the state.

It is our recommendation that agencies review the federal regulations closely to help them better understand the many changes that have occurred over the past seven (7) years. This will better prepare your agency for your next federal/state survey.

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Quality of Patient Star Ratings

By now, providers should have seen a new change with the Home Health Compare (HHC) website with the addition of star ratings. In order to help consumers compare different home health care providers CMS has initiated a 5 star quality rating system. The overall goal is to provide a relative comparison of each provider's performance compared to other providers.

The debut of the first Home Health Quality of Patient Care Star Ratings occurred with the July 16th update of the Home Health Compare website. Agencies were first introduced to their initial Star Ratings when the Quality of Patient Care Stars Provider Preview Reports were placed in their CASPER folders in early April with data that would then be reported on Home Health Compare in July.

Each quarter, agencies will receive a new Quality of Patient Care Stars Provider Preview Report in their CASPER folders. This quarterly report will allow agencies an opportunity to review their data prior to its posting on Home Health Compare the next quarter. Agencies may request a formal review of the data in the Quality of Patient Care Provider Preview Report by sending a request to: HHC_Star_Ratings_Review_Request@cms.hhs.gov.

The home health star rating will summarize some of the current measures of the home health agency's (HHAs) performance measures that are already posted on HHC. The home health star ratings are expected to be an additional tool to support consumer's healthcare decision making and also to provide additional incentive for home health agencies to monitor and improve their care and processes.

There are two Types of Star Ratings on Home Health Compare. They are:

1. Quality of Patient Care Stars Rating beginning July 2015 – these results are derived from OASIS and Claims Data.
2. Patient Satisfaction Stars Rating beginning January 2016 - these results are derived from HH CAHPS Survey Data.

The Quality of Patient Care Star Ratings methodology includes 9 of the 27 currently reported process and outcome quality measures. Those measures are:

Process Measures

1. Timely Initiation of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Influenza Immunization Received for Current Flu Season

Outcome Measures

1. Improvement in Ambulation
2. Improvement in Bed Transferring
3. Improvement in Bathing
4. Improvement in Pain Interfering with Activity
5. Improvement in Dyspnea
6. Acute Care Hospitalization (This is claims-based and calculated for Medicare fee-for-service patients only)

All Medicare certified home health agencies (HHAs) will receive a star rating unless they are a new agency (being less than 6 months old) or they have too few qualifying episodes (that would be less than 20 complete qualifying episodes for each of the included measures) or they don't have enough reported data for at least 5 of the 9 measures that are included in the 5 star calculations.

If you are your agency's designated user possessing the provider's OASIS submitter ID and password, you can access your agency's star rating preview reports through the CASPER system. It will be in the same folder as your annual quality preview reports have been previously posted. If you need help accessing your star preview reports contact the QIES Technical Support Office at 1-800-339-9313 or go to help@QTSO.com.

Education regarding the Quality of Patient Care Star Rating is not the responsibility of the bureau. However,

Home Health Issues

Quality of Patients continued

we have listed below several resources that home health agencies can access for assistance in understanding this new CMS initiative.

- <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html> (CMS website)
- HomeHealthQualityQuestions@cms.hhs.gov (CMS email box for your provider questions)
- <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Quality-of-Patient-Care-Star-Ratings-FAQs-updated-5-11-15.pdf> (CMS Frequently asked questions)

Pay-for-Reporting Performance Requirement

Section 1895(b) (3) (B) (v) (I) of the Social Security Act (the “Act”) states that “for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points.” This “Pay-for-reporting” requirement was implemented on January 1, 2007. However to date, the quantity of OASIS assessment each HHA must submit to meet this requirement has never been proposed and finalized through rulemaking or through the sub-regulatory process. The threshold thus far had been set at ONE OASIS submission each reporting year.

In the CY 2015 Home Health Final Rule (www.gpo.gov/fdsys/pkg/FR-2014-07-07/pdf/2014-15736.pdf) CMS proposed to establish a new “Pay-for-Reporting Performance Requirement” with which provider compliance with quality reporting program requirements can be measured. This performance system is driven by the principle that each HHA will be expected to submit a minimum set of two quality assessments defined as assessments that either create a quality episode of care or could create a quality episode. This new Quality Assessment Only (QAO) metric and report calculates the agency’s compliance with the OASIS reporting requirements by dividing the number of OASIS assessments that can be used for quality measurement by the number of assessments that should be used for quality measurement.

Using the following formula:

$$\text{QAO} = \frac{\# \text{Quality Assessments} \times 100}{\# \text{Quality Assessment} + \# \text{Non-Quality Assessment}}$$

CMS’s ultimate goal is that HHAs will be required to achieve a quality reporting compliance rate of 90 percent or more, as calculated using the above QAO metric. CMS plans to implement this performance requirement in an incremental fashion over a 3 year period beginning with all episodes of care that occur on or after July 1, 2015 in accordance with the following schedule:

- For episodes beginning on or after July 1st, 2015 and before June 30th, 2016, HHAs must score at least 70 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2017
- For episodes beginning on or after July 1st 2016, the required performance levels will be determined through rulemaking in 2015.

Pay-for-Reporting is another CMS initiative the bureau is not responsible for; however, there is information regarding this reporting requirement on the Quality Initiatives website at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html>.



Questions about home health pay-for-reporting can be submitted to:
HomeHealthQualityQuestions@cms.hhs.gov.

Q & A

OASIS Q&As Categories 1-4 – FINAL version was posted by CMS on 07/08/15. These Q&As, updated for use with the new OASIS C1/ICD-10 Data Set, can be accessed at <https://www.qtso.com/hhatrain.html>.

In addition the quarterly Q&As for the last year (July 2014, October 2014, January 2015, and April 2015) were incorporated into the Category 1-4 files where appropriate. The date on these new files is April 2015.

All of these Quarterly Q&As, the latest being published on April 22, 2015 and July 22, 2015, can also be access at <https://www.qtso.com/hhatrain.html>. These new Q&As include significant guidance in relation to:

- Defining “exhaustion” in relation to M1033
- How to answer M1308 and M1309 when two distinct pressure ulcers deteriorate and become one ulcer
- Determining healing status for surgical wounds covered with steri-strips,
- How to answer M1610 when your patient has a penis pouch
- Determining patient ability to manage injectable meds, when in an Assisted Living Facility,
- Determining Types and Sources of Assistance for M2102 when caregiver availability is temporary
- How to answer M2250 and M2400 when wound care includes moist wound healing but your agency is not doing the dressing changes and therefore did not obtain the physician orders for such treatment
- Impact of impaired function/mobility on M1200 Vision
- Surgical wounds related to bone biopsies, abdominal laparoscopies and cryosurgery,
- Use of knee scooter for M1860 Ambulation
- How to report M1500 and M1510 for patients first diagnosed with heart failure upon hospital transfer

Surgical Wounds

One of the new Q&As published with the July 2015 CMS Quarterly Q&As addressed whether to consider burr holes on the head following an evacuation of a subdural hematoma which still has tightly adhered scabs as a surgical wound for M1340. The new CMS guidance states that a burr hole is a hole that is surgically placed in the skull, or cranium and is considered a surgical wound and remains a current surgical wound until the site is completely epithelialized and is without signs/symptoms of infection for approximately 30 days, at which time it becomes a scar.

Agencies are reminded that if you have any type of reference handout that lists what is to be considered a surgical wound and what is not, that you continually update this reference as new guidance is published.

Reminder

Assistive Devices

This is just a reminder to clinicians that in terms of what is an assistive device when answering the OASIS data items, there is no all-inclusive CMS approved list of assistive devices. CMS leaves it up to the assessing clinician to determine if the device the patient is using should be considered an assistive device for that particular patient.

OASIS TIPS

Want to assure your agency is getting the correct case mix points? Following are a few reminders.

M1810 – Clinicians do not always realize that in cases where patients plan on returning to a previous style of dressing after treatment, answering “0-Able to get clothes out of closets and drawers, put them on and remove them...without assistance” could be inappropriate. Clinicians must use their best judgment to determine if clothing modified by patients due to their illness will become routine for the patient. They must determine if there is no reasonable expectation they could return to their normal pre-illness style of dressing. CMS states there is no specific timeframe at which the modified clothing will become routine, so it’s up to the clinician to decide. It’s imperative, therefore, that clinicians ask patients what they usually wear and what their goal is through the course of treatment.

A couple of tips to pass on to your clinicians when answering M1810:

- Be cognizant of physician orders in relation to the patient’s range of motion and weight bearing
 - o A patient who’s physician has ordered not to raise the arms above the heart following removal of a pacemaker would have interference with range of motion and ability to dress. This type of patient may be wearing an altered garment. The altered garment would be a clue to the clinician that this patient needs a higher level of assistance to dress
- Be cognizant of what activities cause your patient pain or shortness of breath
 - o A patient may have doctor’s orders that list restrictions related to weight bearing and pain issues. A patient may say she can pull on her shirt without assistance but if it causes extreme pain or causes her to become short of breath, the clinician would choose a higher level of assistance to dress.

M1840 – If a patient’s ability (not willingness or adherence to instructions) to safely transfer on and off the toilet is not taken into account; this item can be marked incorrectly.

Clinicians have to make sure they assess their patient’s ability to not just transfer on and off the toilet, but also their ability to get to and from the toilet. We all know that each OASIS item stands alone; however, if the clinician has marked response “3 – Able to walk only with the supervision or assistance of another person” for M1860 (ambulation), then answers response “0- Able to get to and from the toilet and transfer independently...” for M1840, this would not be appropriate. Or at least it should send up a red flag for your chart auditors. \If in this scenario M1860 is correct, M1840 “1 – When reminded, assisted or supervised...” or maybe even higher would be more a more appropriate response.



New Resources

CMS has now published all of the necessary data collection resources in order to fully prepare for the implementation of OASIS C1/ICD-10 for October 2015. After October 1, 2015, CMS will be archiving all of the ICD-9 versions of the OASIS Guidance Manual, Data Set and Q&As.

OASIS C1/ICD-10 Guidance Manual

Since our last Bureau Talk there is yet another new OASIS Guidance Manual! To update the guidance to support use of the new OASIS C1/ICD10 Version that will begin starting 10/1/15, CMS posted the new OASIS C1/ICD-10 Guidance Manual. This manual can be downloaded at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html>.

After October 1, 2015, CMS will be archiving all of the ICD-9 versions of the OASIS Guidance Manual, Data Set and Q&As.

Quality Measure Tables

The following two categories of quality measures are used in the Home Health Quality Reporting Program (HH QRP):

1. Outcome measures
2. Process measures.

On 04/16/15, CMS posted newly updated Quality Measure Tables. These new tables are the Home Health Quality Measures – Outcomes (OBQI), Home Health Quality Measures – Process (PBQI) and Home Health Quality Measures – Potentially Avoidable Events (OBQM).

These tables are helpful in understanding what each OBQI, OBQM and PBQI measure means and how the patient episodes get included or excluded from the measure calculations.

These tables are available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html>.

Please share this new documentation with whoever in your agency conducts your Quality Reporting Program.



Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.

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